



Regulatory Education and Action for Patients

● *Seeking Common Ground*

May 7, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-0044-P
P.O. Box 8013
Baltimore, MD 21244-8013.

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program
Stage 2

Dear Administrator Tavenner:

Regulatory Education and Action for Patients (REAP) is an umbrella coalition comprised of patient advocacy groups whose goal is to strengthen current relationships and build new relationships with government agencies that have the responsibility for implementing provisions of the Patient Protection and Affordable Care Act¹, as amended, (PPACA) and to ensure that implementation of the Act's provisions is patient-centric. The unique experience and expertise of each REAP member organization allows REAP to provide the patient voice in a cross-disciplinary manner.

REAP's mission is to communicate issues to Federal and State regulatory bodies, Congress, health care insurers and others that regulate, develop, manage and/or impact health delivery, coverage, cost and availability of services to the United States population. REAP will, through its member organizations, contribute information and perspectives regarding important health care decisions to a degree that has not been possible heretofore by health care advocacy groups in the regulatory arena.

REAP members are very interested in commenting on the proposed rule regarding the electronic health record incentive program. Its members read with interest the proposed rule which specifies the proposed Stage 2 criteria that eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments. The proposed rule specifies payment adjustments under Medicare for covered professional services and hospital services provided by EPs, eligible hospitals, and CAHs failing to demonstrate meaningful use of certified EHR technology and other program participation requirements. These are likewise of interest to REAP members because of their impact on patient care,

¹ Pub.L. 111-148

particularly sections related to interoperability which is essential for patient care coordination. REAP members understand the potential of patient care coordination which is designed to improve patient health and safety, among other patient benefits.

Legislative Intent

The comments below respond to the proposed rule and are influenced by the legislative intent of the authorizing legislation. The Health Information Technology for Economic and Clinical Health Act (HITECH) goals are to improve health care quality, create a national electronic health information exchange, and establish the infrastructure necessary to measure providers' performance.² Section 4101(a) of the HITECH Act added a new subsection (o) to section 1848 of the Social Security Act. Section 1848(o) of the Act established incentive payments for demonstration of meaningful use of certified EHR technology by Eligible Professionals participating in the original Medicare program. The Congressional Record reveals the legislative intent of the law. As summarized by Senator Whitehouse, the goal is not just to provide financial incentives for physicians to purchase technology; the goal is to have doctors use better practice protocols to lower costs and provide better patient outcomes.³ REAP comments are focused on how the rule might be improved consistent with Congressional intent to improve the ability of providers to deliver care resulting in better patient outcomes.

Protection of Information Exchange Must Occur with All Deliberate Speed To Benefit Patients

REAP understands and appreciates the tremendous benefit that coordinated patient care represents for patients. Its members therefore are in support of efforts to enhance such coordination. With increased coordination comes an amplified risk to the privacy to patients, which is why REAP supports all provisions that improve privacy and security protection through encryption and risk assessment. However, concern remains whether patients without personal computers for electronic patient summaries can receive information in a manner that is both accessible and private.

REAP appreciates language in the proposed rule that requires EPs, EOs and CAHs to provide a summary of care document 65 percent of the time when referring or transferring a patient and must also send a summary of care document electronically to external organizations with different EHR vendors 10 percent of the time in 2014. While the requirements are important ones with tremendous patient benefit, REAP is concerned the requirement does not apply in Stage 1, which persists under the proposed rules until 2018.

Likewise, we are concerned the 65 percent rule does not require an electronic copy be sent to a receiving provider. The challenges patients endure when information is not in an exchangeable format are not proposed to be preliminarily addressed until 2014. This approach also does not address the challenges providers who are willing to exchange information face by some IT vendors which proactively block the exchange of patient information. It has come to our attention that even products within the same vendor have been reported to lack integration across sites.

Recommendations:

² See 42 U.S.C.A. § 1395w-4(o)(2) (West Supp. 2010).

³ See 155 CONG. REC. S1,511 (daily ed. Feb. 4, 2009) (statement of Sen. Whitehouse).



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1. The summary of care document should be provided electronically.
2. The rule should retain the 10 percent exchange requirement considering more than half of providers may be using EHRs by 2014.
3. The proposed rule should be modified to prevent or discourage the business practice of blocking information exchange between health care providers.

Patients Will Benefit From CMS Data Regarding Best or Promising Practices

REAP appreciates the challenges any paradigm shift presents to health policymakers. Programs that promote medical care coordination represent a new approach for not only patients and providers but for all in the health care industry. To assure CMS future policy decisions are data-driven whenever possible, REAP recommends CMS maintain its current test for exchange of clinical data so that policymakers have robust, experiential as well as longitudinal data upon which to make future policy decisions regarding the electronic health record incentive program. For example, summaries of care should be shared electronically in 2013 so that standards identified in 2014 are informed by 2013 data. Please recall the financial incentives in this program exist as a result of taxpayer dollars. Those dollars must be expended with fiscal prudence and HHS will not be able to make informed decisions regarding the value of incentive expenditures without the information that tests of exchanges and reports are certain to yield.

Recommendations:

1. Retain the test for clinical information exchange in 2013, but clearly define what providers must exchange based on an actual patient (option 4 in the rule).
2. Report on the results of the test – successful or not – to provide feedback on what is working and so that CMS and ONC can make adjustments as needed to promote information exchange.

Reward Early Adopters of Functional Electronic Health Record Incentive Programs

The patient provider relationship is a strong one and providers who have incurred expenditures in the interest of assuring their patients quickly yield the benefits of coordinated patient care should be rewarded for their early efforts. The current proposed rule language appears to have the likely unintended consequence of punishing those health care providers who have implemented functional systems with enhanced integration because the rule exclusively rewards a single standard regardless of whether that standard works for everyone. By providing a greater amount of time for program

participants to integrate their systems, the proposed rule promotes a “race to the bottom” by encouraging participants to delay health record integration which results in a greater period of time to elapse before patients can reap the rewards of coordinated health care delivery. It also may punish some providers who have adopted more functional systems that can send and receive patient information with more functional exchange standards. REAP reminds CMS of the legislative intent of the program which is to “lower costs and provide better patient outcomes” as noted above. REAP encourages CMS to amend the proposed rule to reward the early adopters by providing electronic health record incentive payments to them as early as possible.

Recommendation:

1. REAP suggests modifying the NPRM to allow providers to use standards that work for them if their systems can be backwards compatible, or in other words if the current systems systems can work with the standard CMS and ONC have chosen as an exclusive standard in the rule.

Assessment of Tobacco Use and Exposure

On page 13713 of the Federal Register, a proposed objective in regard to tobacco use was announced. In addition to requesting input on the assessment threshold for patients 13 years old or older, consideration for other tobacco product use and the effect of exposure to second-hand smoke was discussed.

REAP agrees that accurate information on smoking status provides context to a high number and wide variety of clinical decisions. Consequently, we believe the information collected will be more accurate and effective with an expanded scope. Assessment for smoking should occur earlier than 13 years of age. The peak years for first trying to smoke are between ages 11-13, with a considerable numbers starting even earlier. In a nationwide survey, *Monitoring the Future*, 8.8% of eighth graders reported having smoked by fifth grade (ages 10-11 years).⁴ Similarly, assessment for use of other tobacco products should be included and should begin before age 13. By high school, 15% of US boys were smokeless tobacco users, up 36% since 2003.⁵ Smokeless tobacco use can lead to oral cancer, gum disease, and nicotine addiction.⁶ Finally, assessment of second hand smoke exposure should be included for adults and children for short-term effects such as asthma and longer-term effects such as heart disease and cancer. Nearly 54,000 people die annually from second hand smoke exposure.⁷ Even occasional exposure to secondhand smoke is harmful.⁸

Recommendation:

1. Begin assessment of smoking use earlier than 13 years of age.
2. Assess for use of any other tobacco products earlier than 13 years of age
3. Assess second hand smoke exposure for both short and long-term effects at all ages.

⁴ Johnston, LD, et al, 2008

⁵ Johnston, LD, et al, 2010

⁶ HHS Surgeon General, 1986

⁷ California EPA, 1997

⁸ HHS Surgeon General, 2010



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Conclusion

In closing, REAP members thank CMS for the opportunity to provide the above comments. Please feel free to contact us should you have any questions regarding how the Electronic Health Record Incentive Program might be improved to benefit patients.

Sincerely,

Alpha 1 Association
Alpha 1 Foundation
The ALS Association
C-Change
COPD Foundation
Friends of Cancer Research
HealthHIV
Hypertrophic Cardiomyopathy Association
Kidney Cancer Association
LIVESTRONG - Lance Armstrong Foundation
Lymphoma Research Foundation
National Alliance on Mental Illness
National Patient Advocate Foundation
Prevent Cancer Foundation
Sisters Network

725 15th Street NW, 10th Floor □ Washington D.C. 20005

www.reapforum.org

202-347-5277

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